U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

Issue Date: 24 March 2005

Case No. 2003-BLA-0136

In the Matter of

CILLIS GENE LANKFORD
Claimant

v.

EASTOVER MINING COMPANY
Employer

and

UNDERWRITERS SAFETY AND CLAIMS
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

APPEARANCES:

Robert M. Estep, Esquire
For the Claimant

Gayle G. Huff, Esquire
For the Employer

Before: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER—DENYING BENEFITS

This case arises from a claim for benefits under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq*. (hereinafter referred to as "the Act"), and applicable federal regulations, mainly 20 C.F.R. Parts 412, 718, and 727 ("Regulations").

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as black lung.[1]

At a formal hearing held on September 18, 2003 in Benham, Kentucky, all parties were afforded a full opportunity to present evidence and argument, as provided in the Act and Regulations issued thereunder, found in Title 20, Code of Federal Regulations.[2] The record was held open until November 3, 2003 for the parties to submit closing arguments. Tr. 36. Claimant's brief was received on October 31, 2003, Employer's brief and Employer's exhibit 2 were received on November 3, 2003 and the record is now closed.

At the hearing, the Director's exhibits 1-96, the parties' joint exhibit #1, Claimant's exhibits 1-2, and Employer's exhibit 1 were admitted into evidence. Tr. 5-10.

ISSUES

The following issues remain for resolution:

(1) Whether the miner has pneumoconiosis as defined by the Act;
(2) Whether the miner's pneumoconiosis arose out of coal mine employment;
(3) Whether the miner is totally disabled;
(4) Whether the miner's disability is due to pneumoconiosis.
(5) Whether the miner has established a change in condition pursuant to 20 C.F.R. §§ 725.309 and 725.310 (2000) (duplicate claim and modification);
(6) Whether there was a mistake in a determination of fact pursuant to 20 C.F.R. § 725.310.
(7) Whether the miner has any dependents for purposes of augmentation of benefits under the Act.

(DX 94, Tr. 11-12; 36)

[1] The following abbreviations are used in this decision: DX = Director's exhibit; CX = Claimant's exhibit; JX 1= Joint Stipulation of Evidence by the parties; Tr. = Transcript of the hearing; BCR = Board-certified radiologist; and B = B-reader of x-rays.

[2] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80, 107 (2000) (to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History and Factual Background[3]

Claimant, Cillis Gene Lankford, filed his first claim for benefits on July 29, 1981 and the District Director denied it on February 18, 1983. This case is administratively closed. (DX 16-49).

Claimant filed his second claim for benefits on November 2, 1987, and Administrative Law Judge Thomas Schneider awarded benefits on March 4, 1992. (DX 44). Employer appealed to the Benefits Review Board ("the Board"), which remanded the claim back to Judge Schneider on November 17, 1993. (DX 79-207). Judge Schneider denied benefits on remand on April 18, 1994. (DX 64). Claimant subsequently appealed the decision to the Board, which reversed Judge Schneider's decision and remanded the case to the District Director for an award of benefits. (DX 79-138). Thereafter, Employer filed a motion for reconsideration, the Board granted Employer's motion, and remanded the case to the administrative law judge for further consideration. (DX 79-86). By Decision and Order dated July 22, 1998, Administrative Law Judge Clement J. Kichuk denied benefits. (DX 75). Claimant then appealed Judge Kichuk's decision to the Board, which affirmed the denial on March 31, 2000. (DX 79-19) Claimant appealed further, to the Sixth Circuit Court of Appeals, which affirmed the denial on September 17, 2001. (DX 80)

Claimant filed this, his current claim for benefits, on March 25, 2002, within one year of his prior denial. The District Director denied benefits in a Proposed Decision and Order on November 12, 2002. (DX 90). Claimant disagreed with the District Director's determination and requested a formal hearing on December 2, 2002. (DX 91) The claim was referred to the Office of Administrative Law Judges on March 19, 2003. (DX 94)

At the hearing, Claimant testified that he is 52 years old, has been divorced from Sheila Lankford for seven years, and has two adult sons, neither of whom live with him or are disabled. Claimant currently lives with his fiancée, Dell Wolfenbarger. Tr. 14. Claimant stated that he completed either the 7th or 8th grade and began working for Eastover Mining in 1973. Tr. 14-15. Claimant testified that he passed a physical prior to working in the mines and did not have any breathing problems at that time. Tr. 15. Claimant stated that he worked as a shuttle car operator, and occasionally as a roof bolter, and miner helper and that these jobs required him to work at the face of the coal. *Id.* Claimant described his work environment as dusty and explained that he used a respirator all the time but another machine that they used to measure air levels was left outside and not brought into the mine. Tr. 16.

[3] Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718 (i.e., March 31, 1980), the regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because the miner's last exposure to coal mine dust occurred in Kentucky, this claim arises under the jurisdiction of the U.S. Court of Appeals for the Sixth Circuit. *See Broyles v. Director, OWCP*, 143 F.3d 1348, 21 BLR 2-369 (10th Cir. 1998).

Claimant testified that he developed respiratory problems while working at Eastover and stopped working in 1978 when he injured his right knee and lower back in a mine accident. *Id.* He further explained that he went back to work there against his doctor's advice and worked there until 1981. Tr. 17. Claimant testified that he filed his first black lung claim, which was denied, in 1981, that he filed his second claim in 1991 and the administrative law judge awarded benefits in that claim but that benefits were denied on appeal, and then he filed this claim. Tr. 18. He explained that his condition has worsened since his 1991 claim and he is on more medicine, a ventilator uses four times a day, and inhalers, which he uses every four hours. Claimant described his breathing machine as a nebulizer. Tr. 19. Claimant stated that he does not smoke and only smoked as a teenager with the rest of the guys. *Id.* Claimant testified that the medicine he takes consists of Theodur, Flovent, Serevent, and Albuterol. *Id.*

Claimant testified that he has coughing spells consisting of black and sometimes bloody phlegm every day, that he sleeps on four pillows and still has coughing fits. Tr. 22. Claimant explained that things in the environment, such as cleaning chemicals, affect him and that his fiancée covered the carpet at home with plastic. Tr. 23. Claimant testified that he can walk about 50 feet before getting short of breath and can walk for about five minutes. Tr. 24. Claimant stated that he had a double bypass and had complications during the surgery that resulted from his lung problems. Tr. 24-25. He explained that the doctor had to remove fluid from his lungs with a needle. Tr. 25.

Claimant testified that he can't cut the grass or be around pollen because it makes him cough and gags him. Tr. 26. Claimant testified that he could not go back to work in the coal mines even if he did not have the heart condition. *Id.* Claimant testified that Dr. Baker has been his treating physician for about four to five years, that Dr. Hays prescribed medicine for his cough, and that Dr. Yatteau at Knoxville Hospital is his heart doctor. Tr. 32.

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. They are also based upon my observation of the demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties was carefully reviewed and considered. While the contents of certain medical evidence may appear consistent with the conclusions reached herein, the appraisal of such evidence was conducted in conformance with the quality standards of the regulations. Where pertinent, I have made credibility determinations concerning the evidence.

Medical Evidence

X-Ray Reports[4]

The parties stipulated to the following chest x-ray evidence:

Exhibit No.	Date x-ray	Physician/Qualifications	Interpretation
DX 16-2	9/23/81	Quillen/BCR, B	0/0. Film quality = 1. Both lungs clear with no evidence of small rounded or irregular opacities to indicate presence of pneumoconiosis. No pleural change. Diaphragms normal, no evidence of emphysema or obstructive airway disease.
DX 16-21	9/23/81	Felson/BCR, B	No CWP. Films of excellent quality. No evidence of pneumoconiosis or other significant abnormality.
DX 16-14	9/23/81	Powell	No CWP. Films of excellent diagnostic quality. Heart and mediastinal structures normal. Diaphragms normal. Lungs fully expanded, no infiltrates, no masses. A few scattered parenchymal calcifications. No evidence of pneumoconiosis or silicosis.
DX 16-55	4/8/82	Cole/BCR, B	Completely negative. 0/0. Film Quality = 1.
DX 16-54	4/8/82	Wright	0/0.
DX 3	12/7/87	Baker	1/0; q/q. Film Quality = 1.
DX 3	12/7/87	Kim/BCR, B	Completely negative. Film Quality = 1.

[4] A chest x-ray may indicate the presence or absence of pneumoconiosis. 20 C.F.R. § 718.102(a)-(b). It is not utilized to determine whether the miner is totally disabled, unless complicated pneumoconiosis is indicated, wherein the miner may be presumed to be totally disabled due to the disease.

Exhibit No.	Date x-ray	Physician/Qualifications	Interpretation
DX 3	1/11/88	Kim/BCR, B	Completely negative. Film Quality = 2—fogged.
DX 3	3/15/88	Clarke	1/2, p/q. Film Quality = 1. Diffused general fibrosis bilaterally in ?? lung fields with linear fibrosis of ?? bronchitis. Pneumoconiosis.
DX 3	3/15/88	Halbert/BCR, B	Completely negative. Film Quality = 1.
DX 21 DX 39	3/23/89	Vongkasemsiri	Suggestion of small nodule at the right lower lobe anteriorly. No acute infiltration, consolidation or pneumothorax. Heart not enlarged. Questionable slight increased density at the right lower lung zone laterally.
DX 21 DX 39	4/17/89	Vongkasemiri	No active disease within the Chest.
DX 21 DX 39	4/20/89	Vongkasemiri	Examination taken after the lung biopsy shows no evidence of pneumothorax or pleural effusion. Poorly defined density at the right lower lung zone is again noted.
DX 21 DX 39	4/24/89	Pongdee	Negative chest.
DX 21 DX 39	4/28/89	Pongdee	No acute or active disease. The right chest tube is seen in place.
DX 21 DX 39	5/12/1989	(Name illegible)	Residual postinflammatory changes, right lower lobe.

Exhibit No.	Date x-ray	Physician/Qualifications	Interpretation
DX 21			
DX 39	5/22/89	(Name illegible)	Residual inflammatory scarring of right lower lobe.
DX 55			
DX 58	3/1/91	Dahhan/B	Completely negative. Film Quality = 1.
CX 4	4/30/03	Lakshman	Bi-basilar infiltrate maybe due to post-op atelectatic changes.
EX 1	8/14/03	Dahhan/B	0/0; Negative for CWP. Film Quality = 1.

Pulmonary Function Studies[5]

The parties stipulated to the following pulmonary function study evidence:

Ex. No./ Date	Coop./ Undst/	Age / Height[6]	FEV1	MVV	FVC	FEV1/FVC%	Qualify?	Tracings
DX 16-61/	Good/	31/	4.09	126	4.92	----		No
4/8/82	Good/	70”						No
DX 3/	Good/	34/	3.52	133	4.52	----		No
12/7/87	Good/	69 ½”						Yes
DX 3/	Good/	36/	3.50	--	4.50	----		No
1/13/88	Good/	71”						Yes
DX 3/	Good/	36/	3.3	56	4.1	----		No
3/15/88	Good/	69”						Yes
DX 41/	Good/	39/	3.25	--	4.24	----		No
5/2/91	Good/	69”						Yes

[5] The pulmonary function study, also referred to as a ventilatory study or spirometry, indicates the presence or absence of a respiratory or pulmonary impairment. 20 C.F.R. § 718.104(c). The regulations require that this study be conducted three times to assess whether the miner exerted optimal effort among trials, but the Board has held that a ventilatory study which is accompanied by only two tracings is in “substantial compliance” with the quality standards at § 718.204(c)(1*). Defore v. Alabama By-Products Corp*., 12 B.L.R. 1-27 (1988). The values from the FEV1, as well as the MVV or FVC, must be in the record, and the highest values from the trials are used to determine the level of the miner’s disability.

[6] I must resolve the height discrepancy recorded on the pulmonary function tests. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find that Claimant’s height is 69.2”

Ex. No./ Date	Coop./ Undst	Age / Height[7]	FEV1	MVV	FVC	FEV1/FVC%	Qualify?	Tracings
DX 83/	Good/	48/	2.39	--	3.35	----		No
5/15/00	Good/	69"						Yes
DX 83/	Good/	48/	2.78	--	3.36		83%	No
5/25/00	Good/	69"						Yes
DX 83/	Good/	48/	2.71	--	3.80		71%	No
7/31/00	Good/	69"						No[8]
EX 1/	Good/[9]	51/	2.17	39.0	2.86		71%	No
8/14/03	Good/	68"	*2.05	*32.0	*2.59			Yes

* Results obtained after bronchodilator

Arterial Blood Gas Studies[10]

The parties stipulated to the following arterial blood gas study evidence:

Ex. No.	Date	pO2	PCO2	Qualify?
DX 16-62	4/8/82	98.6	39.8	No
		*66.2	*34.1	No
DX 3	12/7/87	94.9	36.4	No
		*103.2	*37.4	No
DX 39	4/26/89	89.9	44.7	No
DX 41	5/2/91	92	43	No
EX 1[11]	8/14/03	79.0	44.6	No
		85.8	42.9	No

* Results obtained with exercise

[7] I must resolve the height discrepancy recorded on the pulmonary function tests. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find that Claimant's height is 69.2"

[8] The comments to this test indicate that the tracings were not reproducible and raise a question about Claimant's efforts.

[9] The comments indicate that Claimant put forth poor effort on this test.

[10] Arterial blood gas studies are performed to detect impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. 20 C.F.R. § 718.105(a).

[11] The comments indicate that the exercise component of this test was terminated due to fatigue.

Medical Reports

Hospitalization Records and Treatment Notes

The treatment notes of Dr. Glen Baker dating from May 2000 to September 2000 appear in the record at DX 83. These contain various lab reports and progress notes. The progress notes are illegible in terms of the physician's assessment.

Narrative Medical Evidence

Dr. William H. Anderson

Dr. Anderson examined the miner on September 23, 1981 and submitted a report dated November 2, 1981, which appears in the record at DX 16. Dr. Anderson noted that the miner worked eight years underground as a shuttle car operator or working at the face of the mine for Eastover Mining Company. He noted that the miner stopped working in February 1981 due to re-injury of his knee and back. Dr. Anderson recorded that the miner felt short of breath for two years, and prior to his accident, the miner gave up jogging because it made him short of breath. He noted that the miner reported waking up at night due to shortness of breath and then coughs, which makes him feel better. Dr. Anderson noted that the miner has pain in his back and anterior upper chest. He recorded a smoking history that occurred during the miner's childhood, but that lasted only three years and stopped when the miner began work in the mines.

Dr. Anderson noted that the physical examination was normal, and the chest x-ray is essentially normal, with no evidence of pneumoconiosis or silicosis. Dr. Anderson's final diagnoses are: 1) Orthopedic injury resulting in the miner stopping work; 2) No evidence of pneumoconiosis; 3) Normal pulmonary function studies and arterial blood gases.[12]

Dr. Ballard Wright

Dr. Wright examined the miner on April 8, 1982 for the Department of Labor and completed Form CM-988. His report appears in the record at DX 16. Dr. Wright recorded that the miner worked for Eastover Mining Company as a brake man and shuttle car operator from 1972-1981 and worked for EJ & E Railroad doing odd jobs from 1968-1972. Dr. Wright recorded a family history positive for high blood pressure, heart disease, and cancer. He noted that the miner suffers from frequent colds, pneumonia, arthritis, heart disease, and allergies, in addition to problems with his knee and back. Dr. Wright recorded a cigarette smoking history consisting of one pack per day for two to three years and that the miner quit smoking in 1968. Dr. Wright noted that the miner denied cough, sputum production, wheezing, dyspnea, chest pain, and paroxysmal nocturnal dyspnea. The miner's physical exam was essentially normal. Dr. Wright's diagnosis was "no pneumoconiosis" and high blood pressure. He indicated that the miner's condition was not related to dust exposure in the miner's coal mine employment. In addition, Dr. Wright noted that the miner's arterial blood gases were normal.

[12] The actual copies of the pulmonary function study and arterial blood gas study are not in the record.

Dr. Glen Baker

Dr. Baker examined the miner on December 7, 1987 and completed Form CM-988. His report appears at DX 3. Dr. Baker noted that the miner worked for Eastover Mining Company at the face of the mines and as a shuttle car operator from July of 1973 through February 1982. He also recorded that the miner worked for four years for E.J. & E. Railroad.

Dr. Baker recorded the miner's family history as positive for high blood pressure and heart disease in both parents, diabetes in his father, and cancer in an aunt. He recorded that the miner experienced frequent colds, pneumonia, attacks of wheezing, arthritis, allergy to sulfa, high blood pressure, and chest pain—"? dryness in throat or lungs." Dr. Baker recorded a smoking history of one pack per day for two years, and noted that the miner stopped smoking in approximately 1975. Dr. Baker recorded the present illness as cough, sputum, wheezing, dyspnea, for two to three years; hemoptysis with streaks of dark blood for two to three months and ankle edema for three to four years.

Dr. Baker noted that the miner is able to walk ½ mile on level ground, one flight of stairs due to his knee, and doesn't lift or carry more than twenty pounds because of back trouble. Dr. Baker's physical exam recorded blood pressures of 130/74 and 120/74, pulse 84 beats per minute, weight of 181 ¼ pounds and height 69 ½ inches. Lungs were clear with no rales or wheezes noted, and extremities were without cyanosis, clubbing, or edema. Dr. Baker administered objective tests consisting of a chest x-ray, pulmonary function test, and arterial blood gas study, the results of which are set forth above.

Dr. Baker's diagnoses were: bronchitis and something that is illegible. Dr. Baker based his diagnosis on an abnormal chest x-ray that he noted was borderline, and the miner's duration of exposure. He indicated that based on his physical examination of the miner, the miner has an occupational lung disease which was caused by his coal mine employment. Dr. Baker opined that the miner would not be able to do his usual coal mine employment due to his back and leg impairment and he found no pulmonary impairment and moderate non-pulmonary impairment. Dr. Baker opined that the miner does not have a functional impairment which, in and of itself, prevents him from performing his usual coal mine work. He based this opinion on the miner's normal pulmonary function and arterial blood gas studies. Dr. Baker concluded that the miner's disability did not arise from his coal mine employment but is related to musculoskeletal problems.

The record contains a letter from Dr. Baker to the miner's attorney dated April 18, 2002, which appears in the record at DX 85. Dr. Baker stated that he has followed the miner for coal workers' pneumoconiosis, chronic obstructive airway disease, and chronic bronchitis for a couple of years, and that the miner also developed ischemic heart disease. Dr. Baker stated that he last saw the miner on February 28, 2002 and his x-ray continues to show evidence of coal workers' pneumoconiosis, Category 1/0 on the basis of 1980 ILO Classification. On physical examination he noted scattered wheezes.

Dr. Baker stated that he believes the miner does have coal workers' pneumoconiosis, category 1/0, as well as chronic obstructive airway disease with a mild obstructive defect. He opined that with the x-ray evidence of pneumoconiosis and his occupational pneumoconiosis, the miner should have no further exposure to coal dust, rock dust, or similar dust, odors or fumes as it would aggravate his symptoms and may worsen them, as well. Dr. Baker stated that although the miner does not meet the federal standards for disability, with the combination of his cardiac disease and his lung disorder, he believes the miner is totally and permanently disabled for work in the coal mining industry at any time in the future.

Dr. Baker reviewed the miner's medical records and submitted a report dated October 22, 2002. The report appears in the record at DX 89. Dr. Baker opined that the miner has coal workers' pneumoconiosis on the basis of abnormal chest x-ray changes and history of coal dust exposure. Dr. Baker noted that the miner's pulmonary function studies do not fall within the disability range and that based upon the "Guides to Evaluation of Permanent Impairment", Fifth Edition, he would only have a Class II impairment. Dr. Baker stated, however, that under the same guidelines, section 5.8, page 106 of the "Guides" states that a person who develops pneumoconiosis should limit further exposure to the offending agent and this would appear to make the miner totally disabled for further work in the coal mining industry, with the presence of pneumoconiosis and obstructive lung disease. Dr. Baker further stated that it is his opinion that anyone who has x-ray changes of coal workers' pneumoconiosis and abnormal pulmonary function studies should be considered disabled from pneumoconiosis, although he notes that other experts differ from him in this opinion and feel that only a FEV 1 of approximately 60% should be the limit for considering total disability.

Dr. Baker wrote a letter to the miner's attorney dated June 16, 2003. It is designated in the parties' joint stipulation of evidence as CX 1; however, I am re-admitting is as CX 3 because at the hearing, I admitted a subsequent letter from Dr. Baker, which is set forth below, as CX 1. Tr. 8-9. In the letter, Dr. Baker stated that the miner underwent coronary artery bypass grafting on April 19, 2003. He explained that the miner experienced complications of post cardiotomy syndrome with pleural effusions and atelectasis in his left and right lower lobes. Dr. Baker stated that the miner continues to have coal workers' pneumoconiosis and recent pulmonary function studies were not done because of his abnormal x-ray. Dr. Baker noted that on the miner's last examination in October 2002, he had a Class II impairment, and he opined that with the presence of pneumoconiosis, the miner should have no further exposure to coal dust, rock dust, or similar noxious agents and he would be disabled for further work in the coal mining industry.

Dr. Baker's final report is dated September 12, 2003 and appears in the record as CX 1.[13] Dr. Baker reiterated that the miner has coal workers' pneumoconiosis, category 1/0, on the basis of 1980 ILO classification. He opined that the miner also has a mild obstructive ventilatory defect and a class II impairment. Dr. Baker stated that the miner has a cigarette smoking history of about six months and has not smoked in 33 years. Dr. Baker opined that the miner has coal

[13] At the hearing, Employer objected to this report as being outside the 20 day rule. Tr. 8. I admitted the document and gave Employer 30 days to respond. Tr. 8-9.

workers' pneumoconiosis, category 1/0, based on his history of coal dust exposure and abnormal x-ray changes. He further opined that the miner has chronic obstructive airway disease with mild obstructive defect and a class II impairment.

Dr. Harold L. Bushey

Dr. Bushey examined the miner on January 11, 1988 and his report appears in the record at DX 3. Dr. Bushey recorded nine years of underground coal mine employment and noted that the miner stopped working due to a back and leg injury. Dr. Bushey noted that the miner gets short of breath walking up hill, sleeps on three pillows, and awakes coughing and smothering. Dr. Bushey recorded a chronic cough of ten year's duration, with occasionally bloody sputum of approximately ½ cup. He noted that anterior chest pains sometime accompany the cough and that the miner frequently has respiratory infections. Dr. Bushey noted that the miner smoked when he was young for a few months but has not smoked in years.

On physical examination, Dr. Bushey noted that the miner's chest has an increase in A.P. diameter and expands from 37 ½ to 38 ¾ inches with deep breathing. He noted that the lungs have decreased breath sounds and a tight cough. Dr. Bushey performed pulmonary function studies, the results of which are set forth above. He interpreted the miner's chest x-ray as 2/1, p/q and noted that the hilar areas have a few calcified nodes bilaterally. Dr. Bushey diagnosed the miner with chronic lung disease with pulmonary fibrosis compatible with coal workers' pneumoconiosis 2/1, p/q.

Dr. W.F. Clarke

Dr. Clarke examined the miner on March 15, 1988. His report appears in the record at DX 3. Dr. Clarke noted that the miner's chief complaint was shortness of breath, dyspnea, three pillow orthopnea, morning cough, sore chest, and spitting up blood. Dr. Clarke recorded nine and a half years of coal mine employment, with work underground lying track and operating a shuttle car. He noted that the miner was exposed to rock, sand and coal dust. Dr. Clarke recorded that the miner injured his back in the mine and quit thereafter. Dr. Clarke recorded a history negative for tuberculosis, histoplasmosis, lung surgery, chest injury, blood disease, or cardiovascular disease.

Dr. Clarke recorded a smoking history of ½ pack of cigarettes daily that ended nine years prior. Dr. Clarke noted that the miner is 5'9" tall, weighs 186 pounds, and his blood pressure was 132/84. He noted that the miner's EKG was within normal limits. Physical exam revealed inspiratory and expiratory rales and rhonchi bilaterally, with vocal laryngeal stridor of chronic URI, and early gnarling of the nails. Dr. Clarke noted that the miner's pulmonary function test revealed mild restrictive pulmonary disease and mild chronic obstructive airways disease. He noted that the miner's chest x-ray was 1/2, p, q. Dr. Clarke opined, based on the entire examination, that the miner is totally and permanently disabled for all work in a dusty environment, and all manual labor due to coal workers' pneumoconiosis with bronchitis. Dr. Clarke opined that the miner is 100% permanently and totally disabled due to coal workers' pneumoconiosis. Dr. Clarke stated that he was unable to determine any other cause for the miner's disabling dyspnea other than his work in a dusty environment.

Dr. Talmadge V. Hays

Dr. Hays, the miner's treating physician, wrote a letter dated November 21, 1989 which appears in the record at DX 39. Dr. Hays noted that he knows from prior experience that the miner had a protracted work experience in the mining industry, and has been disabled for five to six years due to back and knee injuries. Dr. Hays stated that the present studies offer little objective support for pneumoconiosis "in the classic sense of the word."

Dr. Hays examined the miner and submitted a report dated June 4, 1991, which appears in the record at DX 41. He recorded that the miner was previously disabled due to orthopedic problems from a mine accident. Dr. Hays noted that the miner has an extensive history in underground mining, working at the face of the mine and aspirating particular [sic] debris, including coal and rock dust, on a regular basis. He noted that the miner has a protracted history of chronic bronchitis associated with expectoration of more than a teacup of sputum. Dr. Hays recorded that the miner uses bronchodilators and mucolytic agents for seven to ten years.

Dr. Hays' physical examination revealed a slight increase in the anterior posterior chest dimensions, and breath sounds showed some inspiratory and expiratory wheezing with occasional rhonchi, although breath sounds were relatively quiet. Dr. Hays reviewed a May 1, 1991 chest x-ray and noted small, calcified granulomas in both perihilar areas which are unchanged from 1989. He stated that the picture is consistent with the scarification associated with pneumoconiosis.

Dr. A. Dahhan

Dr. Dahhan reviewed the miner's medical records including treatment reports, biopsy reports, and physician reports and issued a report dated May 9, 1991. Dr. Dahhan testified in a deposition that he is board-certified in internal medicine and pulmonary medicine, and is a B-reader. His report and testimony pertaining to his qualifications appear in the record at DX 34. Dr. Dahhan concluded, based on his review of the medical records and within a reasonable degree of medical certainty, that there is no evidence of occupational pneumoconiosis. He stated that he based this opinion on the normal spirometries at Drs. Clarke and Baker's offices, normal arterial blood gases in 1987 and 1989, negative chest x-ray, negative pathological specimen. Dr. Dahhan stated that he disagreed with Dr. Reinoso's opinion that an open lung biopsy will miss occupational pneumoconiosis. Dr. Dahhan opined that the miner has no objective evidence of pulmonary impairment and/or disability based on the pulmonary function studies, blood gases, and chest x-rays, and that the miner retains the respiratory capacity to continue his previous coal mining employment or a job of comparable physical demand with no evidence of pulmonary condition arising from his coal dust exposure.

Dr. Dahhan reviewed the miner's medical records a second time and issued a report dated June 20, 1991, which appears in the record twice, at DX 55 and 58. Dr. Dahhan reviewed Dr. Hays' June 4, 1991 report and the March 1, 1991 chest x-ray that Dr. Hays referenced. Dr. Dahhan stated that his own interpretation of that x-ray revealed no opacities consistent with pneumoconiosis, ILO classification 0/0. Dr. Dahhan opined that based on his review of the

miner's medical records, he does not believe they reveal evidence of occupational pneumoconiosis and/or pulmonary disability, secondary to coal dust exposure. He opined that the findings on clinical examination and spirometry are those of chronic bronchitis with mild ventilatory impairment, not severe enough to result in total or permanent pulmonary disability.

Dr. Dahhan examined the miner on August 14, 2003, reviewed the miner's medical records, and issued a report dated August 25, 2003 that appears in the record at EX 1. Dr. Dahhan recorded that the miner worked underground operating a shuttle car in the mining industry for eight years, ending in 1989 due to back and knee problems. He noted that the miner is a nonsmoker with a history of daily cough with productive, clear sputum and frequent wheeze, and utilizes three types of inhaler and nebulization therapy, as well. Dr. Dahhan noted that the miner's physical exam was essentially normal and examination of the chest showed a midsternal scar with good air entry to both lungs with no crepitation, rhonchi, or wheezes.

Dr. Dahhan performed arterial blood gas studies, pulmonary function studies, and a chest x-ray. He noted that resting and exercise arterial blood gases showed normal values. Dr. Dahhan stated that the spirometry results were invalid due to poor effort with inconsistent effort, excessive hesitation, and lack of plateau formation. The study was repeated after bronchodilators with no improvement in effort, invalidating the study. Dr. Dahhan noted that the chest x-ray showed cardiac enlargement with post mediastinotomy changes; otherwise, the lung fields are clear with no pleural or parenchymal abnormalities consistent with pneumoconiosis being present. He stated that ILO classification is 0/0.

Dr. Dahhan opined that based on the occupational, clinical, radiological, and physiological evaluation of the miner and within a reasonable degree of medical certainty that there are insufficient objective findings to justify the diagnosis of coal workers' pneumoconiosis. He based this opinion on the normal clinical examination of the chest, normal arterial blood gases at rest and after exercise, normal lung volumes and diffusion capacity and negative x-ray reading for pneumoconiosis. Dr. Dahhan stated that due to poor performance during spirometry testing, direct measurement of his ventilatory capacity is not possible but all other parameters of the respiratory system show no evidence of pulmonary disability.

Dr. Dahhan opined that based on his overall evaluation of the miner, he retains the pulmonary capacity to continue his previous coal mining work or job of comparable physical demand with no evidence of pulmonary impairment and/or disability caused by, related to, contributed to, or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis. Dr. Dahhan subsequently reviewed Dr. Baker's September 12, 2002 letter and submitted a report dated October 20, 2003. This letter appears in the record as EX 2. Dr. Dahhan opined that the miner has no evidence of total or permanent pulmonary disability based on the normal clinical examination of the chest, normal arterial blood gases, and an FEV1 of 71% of predicted, even though the effort was poor. He stated that the miner has not produced valid pulmonary function studies, which makes it difficult to assess if his ventilatory capacity is better than 71% of predicted.

Dr. Dahhan opined that the miner has no findings to justify the diagnosis of coal workers' pneumoconiosis. He opined again that based on his overall evaluation including Dr. Baker's

report, the miner has no evidence of pulmonary impairment and/or disability caused by, related to, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.

Biopsy Evidence

Dr. Stelio Z. Imprecia

Dr. Reinoso performed a right lung biopsy on the miner. The pathologist, Dr. Imprecia, submitted a report dated April 20, 1989, which appears in the record at DX 21. Dr. Imprecia's diagnosis on this report was that "the findings seem to support the transbronchial aspirate as the source of tissue obtained." Dr. Imprecia issued another report dated April 28, 1989, which appears in the record at DX 21. Dr. Imprecia indicated that the specimen consisted of a triangular piece of tissue measuring 1.3 cm, blackish, marble grayish in color with reddish streaking. He indicated that sections showed pulmonary tissue with extensive interstitial tissue hemorrhage with moderately expanded alveolar structures that show one focal area made up of poorly delineated whorl-like bundles of fibrocytic cells of varying degrees of maturity. He stated that the presence of tertiary bronchi are noted which do not appear remarkable, and there is marked thickening of the visceral pleura of the tissue submitted with a moderate degree of hyalinization consistent with fibrosis.

Dr. Imprecia's diagnosis was "pulmonary tissue, marked interstitial hemorrhage with focal fibrosis and pleural fibrosis. No evidence of silicotic nodules nor presence of antracotic pigment lining the lymphatic structures can be identified."

Dr. John L. Crofts

Dr. Crofts reviewed the specimen from the miner's lung biopsy and issued a report dated May 8, 1989 and addressed to Dr. Imprecia. This appears in the record at DX 39. Dr. Crofts described the specimen as a wedge biopsy of lung marked by a central focus of organizing pneumonia and a diffuse modest interstitial infiltrate of benign lymphocytes. He noted that the resolving pneumonia shows confluent alveolar exudates in which spindled cells are predominant. Dr. Crofts noted that there are some normal alveolar septa but most of the septa contain increased numbers of small lymphocytes and there are also some histiocytes which often contain hemosiderin pigment. Dr. Crofts stated that this may be a resolving viral pneumonitis and does not suggest chronic interstitial lung disease of the progressing fibrotic type. He noted that other possibilities might be suggested if he had access to a detailed clinical history and x-ray findings.

Dr. Horacio Reinoso

Dr. Reinoso subsequently summarized his findings during the biopsy in a letter dated July 19, 1989, which appears in the record at DX 21. Dr. Reinoso performed two fine-needle biopsies. The first attempt was non-diagnostic, and the second was diagnosed as lymphoid tissue, so an open lung biopsy was performed. This biopsy suggested pulmonary tissue, bronchial tissue, and marked thickening of the visceral pleura. Dr. Reinoso noted that he found no evidence of silicotic nodules, but this does not rule out silicosis, which, he explained, is a nodular disease invading small areas of pulmonary parenchyma and which make it difficult to reach them

in a biopsy without endangering the patient. Dr. Reinoso stated that in spite of the negative biopsies, he still agrees with Dr. Clark that the miner suffers from ventilatory impairment producted [sic] by the breathing of irritants associated with his coal mine employment and that pneumoconiosis is the most likely culprit.

Conclusions of Law

Length of Coal Mine Employment

The parties' agree that the miner was a coal miner within the meaning of the Act for at least 8 years. Tr. 11.

Date of Filing

Claimant filed his claim for benefits under the Act on March 25, 2002. (DX 81)

Responsible Operator

Eastover Mining Company is the Responsible Operator and will provide payment of any benefits awarded to Claimant.

Dependents

Claimant testified that he has two adult sons who are not disabled and do not live with him. Tr. 14. Additionally, Claimant testified that he is divorced and currently lives with his fiancée. *Id.* As there is no evidence in the record that Claimant's former wife is receiving any support or "substantial contribution" from Claimant, Claimant is considered to have no dependents for purposes of augmentation of benefits under the Act. *See* 20 C.F.R. §§ 725.206 and 725.207 (2001).

Duplicate Claim and Modification

Claimant submits that the evidence establishes a material change in condition pursuant to 20 C.F.R. § 725.309(d) (2001). This section provides that if a claimant files a claim *more than one year* after a previous claim is finally denied, the later claim shall be considered a subsequent claim for benefits (emphasis added). As such, the new evidence submitted in connection with the subsequent claim must establish a change in at least one condition of entitlement previously adjudicated against the claimant, or the claim shall be denied. *Id.* The Sixth Circuit Court of Appeals finally denied claimant's previous claim on September 17, 2001 and he filed this claim on March 25, 2002, which is six months after the final denial of his previous claim. Accordingly, the subsequent claims provision set forth above does not apply to Claimant's claim.

The regulations further provide that modification of an order may be sought at any time before one year after the denial of the claim. Specifically, the terms of an award or the decision to deny benefits may be reconsidered upon the showing of a "change in conditions" or a "mistake in a determination of fact." 20 C.F.R. § 725.310 (2001). In evaluating a request for

modification, it is not enough that the administrative law judge conduct a substantial evidence review of the district director's finding. Rather, the parties are entitled to *de novo* consideration of the issue. *Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156 (1990), *aff'd on recon.* 16 B.L.R. 1-71 (1992); *Dingess v. Director*, *OWCP*, 12 B.L.R. 1-141 (1989); *Cooper v. Director, OWCP*, 11 B.L.R. 1-95 (1988). In addition, even if a change in conditions is not established, evidence must be considered to determine whether a mistake in a determination of fact was made, even where no specific mistake of fact was alleged. *See O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971); *Consolidation Coal Co. v. Director, OWCP [Worrell]*, 27 F. 3d 227 (6th Cir. 1994). In reviewing the evidence of record, both old and new, I find that Judge Kichuk did not make a mistake in a determination of fact with the evidence that was before him at that time.

Claimant's previous claim was denied because the evidence did not establish that he is totally disabled due to pneumoconiosis. Thus, in order for Claimant to prove a change in conditions, the new evidence must be evaluated to determine whether those elements can now be established.

Standard of Review

Standard of Review

The administrative law judge need not accept the opinion of any particular medical witness or expert, but must weigh all the evidence and draw his/her own conclusions and inferences. *Lafferty v. Cannelton Industries, Inc.*, 12 B.L.R. 1-190 (1989); *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986); *Todd Shipyards Corp. v. Donovan*, 300 F.2d 741 (5th Cir. 1962). The adjudicator's function is to resolve the conflicts in the medical evidence; those findings will not be disturbed on appeal if supported by substantial evidence. *Lafferty, supra*; *Fagg v. Amax Coal Co.*, 12 B.L.R. 1-77 (1988); *aff'd*, 865 f.2d 916 (7th Cir. 1989); *Short v. Westmoreland Coal Co.*, 10 B.L.R. 1-127 (1987); *Piccin v. Director, OWCP*, 6 B.L.R. 1-616 (1983); *Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 B.L.R. 2-84 (7th Cir. 1983).

In considering the medical evidence of record, an administrative law judge must not selectively analyze the evidence. *See Wright v. Director, OWCP*, 7 B.L.R. 1-475 (1984); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Crider v. Dean Jones Coal Co.*, 6 B.L.R. 1-606 (1983); *Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 B.L.R. 2-84 (7th Cir. 1983); *see also Stevenson v. Windsor Power House Coal Co.*, 6 B.L.R. 1-1315 (1984). The weight of the evidence, and determinations concerning credibility of medical experts and witnesses, however, is for the administrative law judge. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986); *Brown v. Director, OWCP*, 7 B.L.R. 1-730 (1985); *see also Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Henning v. Peabody Coal Co.*, 7 B.L.R. 1-753 (1985); *Peabody Coal Co. v. Benefits Review Board*, 560 F.2d 797, 1 B.L.R. 2-133 (7th Cir. 1977).

As the trier-of fact, the administrative law judge has broad discretion to assess the evidence of record and determine whether a party has met its burden of proof. *Kuchwara v. Director, OWCP*, 7 B.L.R. 1-167 (1984). In considering the evidence on any particular issue, the administrative law judge must be cognizant of which party bears the burden of proof. Claimant

has the general burden of establishing entitlement and the initial burden of going forward with the evidence. *See White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

The Existence of Pneumoconiosis and the Application of Collateral Estoppel

This claim was initially before Administrative Law Judge Thomas Schneider, who found that the miner suffered from legal pneumoconiosis. After subsequent appeals, the case was remanded to Judge Schneider who, at that point, was no longer with the Office of Administrative Law Judges. Thus, the case was assigned to Judge Kichuk who, on remand, affirmed Judge Schneider's finding that the miner suffered from pneumoconiosis. When the case was finally appealed, the Sixth Circuit noted that Employer did not contest the administrative law judge's finding of pneumoconiosis. *See* DX 80 at 4. This raises the threshold issue of whether Employer is collaterally estopped from relitigating the issue of coal workers' pneumoconiosis.

The following elements must be satisfied prior to the application of collateral estoppel or issue preclusion. The issue to be precluded must be:

1) the same as that involved in the prior action, and
2) actually litigated in the prior action, and
3) essential to the judgment in the prior action.

In addition, the party against whom estoppel is invoked must have been fully represented in the prior litigation and the parties in both actions must be the same or in privity. All of these elements are met in this case; therefore, I find that Employer is collaterally estopped from relitigating the issue of coal workers' pneumoconiosis here.

In addition, as I found that this claim is not a duplicate claim but, more properly, a petition for modification of an order or award, the more applicable question is whether Judge Kichuk made a mistake in fact in finding that the miner suffers from pneumoconiosis. However, as I explained above, after careful review of the entire record, including both old and new evidence, I find that Judge Kichuk did not make a mistake in a determination of fact. Accordingly, for the reasons set forth above, I find that Claimant has established the existence of pneumoconiosis, as set forth in Judge Kichuk's decision.

Evidence of Total Disability

Claimant's claim was denied because he failed to prove that he is totally disabled due to pneumoconiosis. Total disability is defined as pneumoconiosis that prevents or prevented a miner from performing his usual coal mine employment or other comparable gainful work. 20 C.F.R. §§ 718.305(c), 718.204(b)(1) (2001). A finding of total disability may be based on criteria found in § 718.204(b)(1), which provides that a miner will be considered totally disabled if the irrebuttable presumption set forth in § 718.304[14] applies, or may be established by criteria

[14] There is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if a chest x-ray yields one or more large opacities (greater than 1 centimeter) and would be classified as Category A, B, or C as further specified in the Regulation.

found in § 718.204(b)(2), which consists of qualifying pulmonary function studies, qualifying blood gas studies, the existence of cor pulmonale with right-sided congestive heart failure, and the opinion of a physician, exercising sound medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concluding that the miner's pulmonary condition prevents him from performing his usual coal mine work.

Because the record contains no x-ray readings recording large opacities, the irrebuttable presumption at § 718.304 does not apply to this claim for benefits.

The record contains nine pulmonary function studies, none of which produced qualifying values. Thus, Claimant has not established total disability via the pulmonary function study evidence.

The record also contains the results of five arterial blood gas studies, none of which are qualifying. Therefore, Claimant has not established total disability via the arterial blood gas study evidence.

No evidence in the record suggests that the miner suffers from cor pulmonale with right-sided congestive heart failure; therefore, he has not established total disability by § 718.204 (b)(2)(iii).

The miner may also establish total disability by the reasoned medical opinion of a physician. 20 C.F.R. § 718.204(b)(2)(iv). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, and the claimant bears the burden of establishing by a preponderance of the evidence the existence of the element. *Mazgaj v. Valley Camp Coal Co.*, 9 BL.R. 1-201, 1-204 (1986). A physician who compares the exertional requirements of the miner's usual coal mine employment against his physical limitations may make a finding of total disability. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000).

There are fourteen narrative medical reports in the record, which include multiple reports from Drs. Baker, Hays, and Dahhan. In addition, there are three biopsy reports in the record by Drs. Reinoso, Crofts, and Imprecia. Of the biopsy reports, only Dr. Reinoso provided an opinion pertaining to the miner's disability status. He stated that in spite of the negative biopsies, he agrees with Dr. Clark that the miner suffers from a ventilatory impairment produced by the breathing of irritants associated with his coal mine employment.

Of the medical reports, Drs. Anderson, Wright, Bushey and Hayes did not specifically address the miner's ability to perform his previous coal mine work or comparable work. Dr. Baker initially opined, in 1987, that the miner does not have a functional impairment which, in and of itself, prevents him performing his usual coal mine work. However, in subsequent reports, Dr. Baker opined that the miner has a Class II impairment and should have no further exposure to coal or other dust, odors, and fumes. In addition, Dr. Baker stated that although the miner does not meet the federal disability standards, with the combination of his cardiac disease and lung disorder, the miner is totally and permanently disabled for work in the coal mining industry in the future. Dr. Clarke opined that the miner is totally and permanently disabled for all work in a dusty environment, and all manual labor due to coal workers' pneumoconiosis with

bronchitis. Dr. Dahhan initially opined, in 1991, that the miner has no objective evidence of pulmonary impairment or disability and that the miner retains the respiratory capacity to continue his previous coal mine employment or a job of similar demands. Dr. Dahhan subsequently opined, in 2003, that the miner retains the pulmonary capacity to continue his previous coal mining work or a job of comparable physical demand with no evidence of pulmonary impairment or disability.

Of the medical opinions addressing the miner's disability status, Drs. Clarke, Baker, and Reinoso opined that the miner is totally disabled and Dr. Dahhan opined that he is not. All three of the physicians based their opinions on objective tests and physical examinations; therefore, I find them to be well documented. I find Dr. Clarke's opinion entitled to little weight. Although he diagnosed the miner with mild restrictive and obstructive disease, he opined that the miner is totally and permanently disabled from all manual labor, and does not discuss the miner's impairment in relation to the demands of his previous coal mine work. I also find Dr. Reinoso's opinion to be of little weight. He does not discuss the miner's abilities in terms of the demands of his previous coal mine employment or similar work and he based his opinion on Dr. Clarke's opinion, which I found to be entitled to little weight.

Dr. Baker's opinion is based primarily on the fact that the miner should not be further exposed to dust and fumes, which does not address the central question of whether the miner is capable of performing his previous coal mine work or comparable work. In addition, while Dr. Baker acknowledges that the miner does not meet the federal disability guidelines, he explains that the miner is totally and permanently disabled from work in the coal mining industry due to a combination of his cardiac disease (coronary artery disease post-bypass) and lung disorder. Dr. Baker does not differentiate between the two disorders, nor does he discuss the demands of the miner's previous coal mine employment in relation to his respiratory capacities. Therefore, I find that his opinion is entitled to less weight.

Dr. Dahhan diagnosed mild ventilatory impairment but opined that it is not severe enough to result in total or permanent pulmonary disability and that the miner retains the pulmonary capacity to continue his previous coal mining work or a job of comparable physical demand. Because Dr. Dahhan discusses the miner's pulmonary capacity in relation to his ability to perform his previous coal mine work or similar work, I find that it is better reasoned than the differing opinions of Drs. Clarke, Baker, and Reinoso and is entitled to greater weight.

Weighing all the evidence pertaining to total disability together, both old and new, I find that Claimant has not established by a preponderance of the evidence that he is totally disabled pursuant to 20 C.F.R. § 718.204(b). Moreover, as Claimant has not established that he is totally disabled, he cannot establish that he is totally disabled due to pneumoconiosis.

Entitlement to Benefits

Claimant failed to establish he is totally disabled, which is an essential element of entitlement. Therefore, he is not entitled to benefits under the Act.

Attorney's Fees

The award of attorney's fees under the Act is permitted only in cases in which the claimant is entitled to the receipt of benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of Cillis Gene Lankford for black lung benefits under the Act is hereby denied.

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JOSEPH E. KANE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this Decision and Order was filed in the Office of the District Director, by filing a notice of appeal with the *Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601*. A copy of a notice of appeal must also be served on Donald S. Shire, Esq., Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.